ARIZONA DEPARTMENT OF HEALTH SERVICES, OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS
TBI/SCI/CYSHCN BILLING AND INVOICE PACKET
SCI DIRECT CARE SERVICES DETAIL REPORT
CONTRACTOR NAME: ADHS PO#
ADHS CONTRACT #   State Fiscal Year 2008
BILLING MONTH:

Date:

FRC Name	Member Name	Middle Initial	Referral Date	Sex	DOB	Type of Health Insurance	Insurance or AHCCCS #	Referred Health Plan	Services Requested	Status	Planned Start Date	Reason for denial or delay	Type of Services	# Of Units	Costs	Cost per Unit	Type of Services	# Of Units	Costs	Cost per Unit	Type of Services	# Of Units	Costs	Cost per Unit	Type of Services	# Of Units	Costs	Cost per Unit	Type of Services	# Of Units	Costs	Cost per Unit	Type of Services	# Of Units	Costs	Cost per Unit	TOTAL

Column groups: MEMBER INFORMATION (columns 1–7); REFERRALS TO OTHER PAYERS (columns 7–12); APPROVED DIRECT CARE SERVICES (repeated, columns 13–36)